STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155680	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEWOOD HEALTH CAMPUS	2494 N LEBANON ST LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 15, 16, 17, 18 & 19, 2011 Facility number: 002703 Provider number: 155680 AIM number: 200309250 Survey team: Linda Campbell, RN, TC Christi Davidson, RN Courtney Hamilton, RN Census bed type: SNF/NF: 40 NF: 14 Residential: 35 Total: 89 Census payor type: Medicare: 25 Medicaid: 18 Other: 46 Total: 89 Sample: 14 Supplemental Sample: 3 Residential: 8 These deficiencies also reflect state	F0000	Submission of this plan of correction does not constitute an admission by Homewood Health campus of any wrong-doing or failure to comply with the Federal or State Regulations. Homewood Health Campus submits this plan of correction as its letter of credible allegation and is requesting a desk review. All corrective actions will be completed by 09.02.2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed on August 22, 2011 by Bev Faulkner, RN			
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure interventions related to alarms, footwear, and toileting were in place to prevent residents from falling resulting in a resident (#36) sustaining a fractured neck. This practice affected 5 of 7 residents with falls in a sample of 14. (Residents #17, #36, #44, #45, #50). Findings include: 1. Resident #36's record was reviewed on 08/16/2011 at 1:35 P.M. Diagnoses included but were not limited to diabetes, congestive heart failure (CHF), and severe cardiomyopathy. A MDS [Minimum Data Set] assessment, dated 02/20/2011, indicated the resident required supervision and a one person physical assist for transfers and for toilet use. The MDS indicated Resident #36	F0323	Submission of this plan of correction does not constitute an admission by Homewood Health campus of any wrong-doing or failure to comply with the Federal or State Regulations. Homewood Health Campus submits this plan of correction as its letter of credible allegation and is requesting a desk review or a request for a revisit immediately after September 18, 2011. F - 323 Resident # 36 was immediately reassessed by physical therapy to determine if appropriate interventions were in place to prevent the resident from falling. All residents that are determined to be at risk for falls have the potential	09/02/2011

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	required the use of a walker for mobility. The resident was admitted to the hospital for congestive heart failure and returned to the facility on 3/11/11. A nursing admission assessment and data collection form, dated 03/11/2011, indicated Resident #36 was independent with use of a wheelchair. The form indicated resident "has disease or condition that predisposes to falls...Y [yes] circled... Takes meds that may affect balance, cognition or gait....Y circled..." The safety plan of care section of the form indicated no interventions were checked. The nursing assessment indicated resident experienced urge incontinence and "...can't get to bathroom in time..." The form indicated resident was alert and oriented. A care plan, dated 04/13/2011, indicated resident fell 03/29/2011. Interventions marked indicated "...invite, encourage, remind, escort to activity programs consistent with resident interests to enhance physical strengthening needs...." An accident/incident report, dated 03/29/2011 at 12:15 A.M., indicated..."res [resident] found on floor at foot of lazy boy chair, lying on left side, states did not know how she got from chair to floor		to be affected by the alleged deficient practice. All residents were immediately reassessed to assure appropriate interventions were in place. Nursing staff were in serviced on our Fall Prevention Plan & on notifying the DHS/ designee immediately to assist with focus on root-cause analysis of falls & appropriateness of interventions. An audit tool was created to monitor each resident falling, to assess if risk assessment was completed, care plans updated, reviewed in morning stand up meeting by the IDT, reviewed in “Clinically at Risk” (CAR) meeting, documentation & orders reviewed & interventions in place & functioning. This audit tool will be completed by the DHS/ designee 5 x week for 1 month and 3 x week for 5 months & weekly thereafter. All results will be reported each month to QA committee for 6 months for review & changes to ensure the deficient practice will not occur. Resident # 45 was immediately reassessed by physical therapy to determine appropriate interventions were in place to prevent resident from falling. All residents that are determined to	

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	AOx3 [alert and oriented times three]. No visible injuries noted. Physician statement/orders: observe... Additional information: found out that [res] took sleep aide [sic] as prescribed prn [as needed] reminded [res] to lie down in bed. [Res] requesting to sit up in chair." An interview with the DON on 08/16/2011 at 2:20 P.M., indicated Resident #36 had taken Ambien [sleeping pill] prior to the fall. The DON indicated resident refused to go to bed and wanted to sit in her recliner. A Fall Circumstance, Assessment, and Intervention form provided by the DON on 08/16/2011 at 2:20 P.M., indicated resident fell on 03/29/2011 at 12:15 A.M. The form indicated Resident #36 was "... transferring herself...safety equipment in place and functioning at time of incident...N [no] circled." The fall risk reassessment completed on the form indicated "...Resident requires assistance to transfer.. N circled.... Resident requires assistance to ambulate safely with or without assistive devices...N circled...Resident refuses to comply with safety measures such as call light use, alarms, appliances, etc...N circled." The prevention update completed on the form indicated, "...instructed to always use call light and encouraged to go to bed p [after]		be at risk for falls have the potential to be affected by the alleged deficient practice. All residents were immediately reassessed to assure appropriate interventions were in place. Nursing staff were in serviced on our Fall Prevention Plan & on notifying the DHS/ designee immediately to assist with focus on root-cause analysis of falls & appropriateness of interventions. A toileting program was established by nursing for this resident. CNA assignment sheets were updated to alert cnas of resident-specific toileting plan. A toileting schedule book was created for the cnas that contain residents with toileting care plans and bowel & bladder sheets to initial to ensure cnas are following the toileting plan. Resident's fall care plan was updated to include her day programming on our Legacy Lane dementia program. An audit tool was created to monitor each resident for falling, to assess if risk assessment was completed, care plans updated, reviewed in morning stand up meeting by the IDT, reviewed in CAR, documentation & orders reviewed & interventions in place & functioning. This audit tool will be completed by the DHS/	

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	becoming sleepy...neurochecks initiated...." An accident/incident report, dated 03/29/2011 at 4:40 A.M., indicated..."res sitting in chair asleep at 4:20 A.M., roommate call out [sic] at 4:40 A.M., when res fell getting up call lite [sic] on armrest." The report indicated "....observed on floor...no apparent injury.... neck pain...." A nurses note, dated 03/29/2011 8:20 A.M., indicated "Late entry...d/c [discontinue] Ambien 10mg [milligrams] PO [by mouth] QHS [every night at bedtime], x-ray of L [left] side neck spine et [and] clavicle area, r/t [related to] pain c [with] recent falls...." A nurses note, dated 03/29/2011 at 1:30 P.M., indicated "...received x-ray result via fax of residents L side neck/spine et clavicle area, discussed results with [nurse practitioner]. Writer et NP [nurse practitioner] assessed resident, she was c/o [complaining of] headache et neck pain. NP wrote new orders to send to ER [emergency room] c cervical collar et hold coumadin [blood thinner] ... EMS called...." A Fall Circumstance, Assessment, and Intervention form provided by the DON		designee 5 x week for 1 month and 3 x week for 5 months & weekly thereafter. All results will be reported each month to QA committee for 6 months for review & changes to ensure the deficient practice will not occur. Resident # 50 was immediately reassessed by physical therapy to determine if appropriate interventions were in place to prevent the resident from falling. All residents that are determined to be at risk for falls have the potential to be affected by the alleged deficient practice. All residents were immediately reassessed to assure appropriate interventions were in place. Nursing staff were in serviced on our Fall Prevention Plan & on notifying the DHS/ designee immediately to assist with focus on root-cause analysis of falls & appropriateness of interventions. A toileting program was established by nursing for this resident. CNA assignment sheets were updated to alert cnas of resident-specific toileting plan.	

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	on 08/16/2011 at 2:20 P.M., indicated resident fell on 03/29/2011 at 4:40 A.M. The form indicated Resident #36 "...found on the floor...sitting in chair fell asleep fell out." The form indicated "...sleeping pill given..." The fall risk re-assessment completed on the form indicated..."Resident requires assistance to transfer...Y circled...Resident requires assistance to ambulate safely with or without assistive devices...Y circled....Resident requires use of an assistive device and/or often forgets to use device...Y circled..." The prevention update completed on the form indicated, "....neurochecks, bed and or chair alarm, bed in low position...." A history and physical from the hospital, dated 03/29/2011, indicated, "...resident who sustained 2 falls...she states she hit the right side of her head...the family believes she was given a sleeping pill before she went to sleep and got up on her own....radiology studies...CT [cat scan] of her neck shows C2 [cervical spine #2] vertebral body fracture and C5 fracture...." A nursing admission, assessment and data collection form, dated 03/31/2011, indicated Resident #36 was admitted from the hospital with C2 and C5 fractures with a cervical collar on. The form indicated resident was dependent on staff with an		A toileting schedule book was created for the cnas that contain residents with toileting care plans and bowel & bladder sheets to initial to ensure cnas are following the toileting plan. An audit tool was created to monitor each resident falling, to assess if risk assessment was completed, care plans updated, reviewed in morning stand up meeting by the IDT, reviewed in CAR, documentation & orders reviewed & interventions in place & functioning. This audit tool will be completed by the DHS/ designee 5 x week for 1 month and 3 x week for 5 months & weekly thereafter. All results will be reported each month to QA committee for 6 months for review & changes to ensure the deficient practice will not occur. Resident # 17 was immediately reassessed by physical therapy to determine if appropriate interventions were in place to prevent the resident from falling. All residents that are determined to be at risk for falls have the potential to be affected by the alleged deficient	

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	assist of one for grooming, transfers, bathing, dressing and toileting. The form indicated resident was experiencing moderate amount of pain frequently in her neck. An interview with the DON on 08/16/2011 at 4:30 P.M., indicated after the first fall, the nurse had encouraged Resident #36 to go to bed but she was placed back in the recliner. The nurse had made sure her call light was in reach. DON indicated no other interventions were initiated and indicated resident's mental status was likely affected by the use of the sleeping pill. An interview with the MDS Coordinator during initial tour on 08/15/2011 at 9:35 A.M., indicated Resident #36 had fallen in the facility and had received the cervical fractures. The MDS Coordinator indicated the resident had a setback from the fractures, resulting in decreased mobility. Resident had recently had the cervical collar removed and had been undergoing therapy. Interview on 8/19/11 at 10:50 A.M., with the Executive Director indicated there was no neurological assessment on the investigation form after the first fall. She stated "if the nurse thought there was a problem with her orientation, she wouldn't		practice. All residents were immediately reassessed to assure appropriate interventions were in place. Nursing staff were in serviced on our Fall Prevention Plan & on notifying the DHS/ designee immediately to assist with focus on root-cause analysis of falls & appropriateness of interventions. A toileting program was established by nursing for this resident. CNA assignment sheets were updated to alert cnas of resident-specific toileting plan. A toileting schedule book was created for the cnas that contain residents with toileting care plans and bowel & bladder sheets to initial to ensure cnas are following the toileting plan. An audit tool was created to monitor each resident falling, to assess if risk assessment was completed, care plans updated, reviewed in morning stand up meeting by the IDT, reviewed in CAR, documentation & orders reviewed & interventions in place & functioning. This audit tool will be completed by the DHS/ designee 5 x week for 1 month and 3 x week for 5 months & weekly thereafter. All results will be reported each month to QA committee for 6 months	

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	have put her back in the recliner." 2. The record for Resident #45 was reviewed on 08/18/11 at 8:45 a.m. Diagnoses included, but were not limited to, cerebral vascular accident, vertigo, depression, hypertension, and osteoporosis. The most recent quarterly Minimum Data Set (MDS) Assessment, dated 06/22/11, indicated Resident #45 had impaired cognition. Resident #45 missed reporting the correct year by 2-5 years, recalled 2 of 3 words after first attempt, but recalled 0 of these 3 words later in the assessment. Resident #45 was assessed to need extensive assistance with one person physical assist for transfers and toilet use. The MDS indicated the resident used a wheelchair. When moving from seated to standing position or moving on and off the toilet, Resident #45 was not steady		for review & changes to ensure the deficient practice will not occur. Resident # 44 was immediately reassessed by physical therapy to determine if Appropriate interventions were in place to prevent the resident from falling. Resident was discharged to home 8/27/11. Date of Compliance: 9/2/11	

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	and could not stabilize without human assistance. The MDS indicated Resident #45 had two or more falls without injury since admission. A recapitulation dated for 08/01/11 through 08/31/11 indicated, "...Apply Velcro self-releasing belt to w/c for resident safety. Check every shift...." A care plan, dated 07/12/2011, titled, "Restraint/Enabler," indicated, Resident #45 had poor safety awareness and had a history of falls due to dementia. One goal listed was, "...no increased incidence of falls/injuries...." A care plan, dated 07/12/2011, titled, "Falls," indicated, "At risk for fall/injury AEB [as evidence by] History of Falls...R/T [related to] Disease process/condition (list): Dementia...." Interventions included, but were not limited to, "...Call light within reach...Provide/monitor use of adaptive devices...Wheelchair...Lock breaks [sic] on bed, chair, etc before transferring...Appropriate footwear...Additional approaches: Sensor alarm to bed...Velcro self-release seat belt to w/c [wheel chair]...Offer to toilet frequently while awake...." A Fall Circumstance, Assessment and			

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	Intervention form, dated 05/08/11, indicated a certified nursing assistant heard the resident fall at 7:30 a.m., in the resident's bathroom. The form indicated Resident #45 was transferring self. Coccyx was listed as injury location. The form indicated, "...Equipment inspection: Safety equipment in place and functioning at time of incident?...." A capital "N" was circled next to that line. The form indicated, "...wheelchair brakes locked?...." A capital "N" was circled next to that line. The "Fall" care plan had an entry dated 05/08/11 that indicated, "...maintain current fall precautions keeping resident safe...." A Fall Circumstance, Assessment and Intervention form, dated 06/09/11, indicated Resident #45 was found on the floor of the bathroom.. The boxes for transferring self and toileting were checked related to the activity at time of fall. The form indicated, "...Wheelchair brakes locked?...." A capital "N" was circled next to this line. The "Fall" care plan had an entry dated 06/09/11 that indicated, "...continue all safety measures to keep safe when...falls...." A Fall Circumstance, Assessment and Intervention form, dated 06/14/11, indicated			

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	Resident #45 was found on the floor of the room at 10:00 a.m. The form indicated the activity at the time of the fall was transferring self. The "Fall" care plan had an entry, dated 06/14/11, that indicated, "...continue all safety measures...." A Fall Circumstance, Assessment and Intervention form, dated 07/22/11, indicated Resident #45 was found on the floor at bedside. The form indicated the activity at the time of the fall was transferring self. The form indicated, "...Equipment inspection:...Wheelchair brakes locked?...." A capital "N" was circled next to that line. The "Fall" care plan had an entry dated 07/22 [no year] that indicated, "...continue...safety measures...." During an interview on 08/18/11 at 1:10 p.m., when asked about new interventions after each fall, the Director of Nursing (DoN) indicated, "We didn't know what else to do." The DoN indicated Resident #45 recently started day programming on the dementia unit. 3. On 8/15/11 at 11:15 A.M., Resident #50 was observed in his room. There was a sensor alarm and scoop mattress in place on the bed. There was a floor mat next to			

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	the bed. On 8/17/11 at 10:45 A.M., Resident #50 was observed sitting in his wheelchair in the hallway. There was an alarming seat belt in place. The record for Resident #50 was reviewed on 08/16/11 at 10:30 a.m. Diagnoses included, but were not limited to, history of falls, history of cerebral vascular accident, hypertension, depression and diffuse spasticity. The most recent quarterly Minimum Data Set (MDS) Assessment, dated 06/08/11, indicated Resident #50 was cognitively impaired. The mental status questions were answered by staff. The MDS indicated Resident #50 had a short and long-term memory problem. The MDS indicated Resident #50 was severely cognitively impaired. The MDS indicated Resident #50 required extensive assistance with two or more person assist for transfers and toilet use. The MDS indicated the resident used a wheelchair and was only able to stabilize with human assistance. The MDS indicated Resident #50 had two or more falls without injury since admission. A recapitulation, dated for 08/01/11			

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	through 08/31/11, indicated, "...self-releasing seat belt to w/c [wheelchair] for safety & check function/placement every shift...." A physical therapy discharge summary, dated 06/22/11, indicated, "...has had a decline in his functional mobility since falling out of his W/C on 05/13/11...resident with hx [history] falls and current use of self-releasing seat belt...able to ambulate only with assist...D/C [discharge] due to reaching max potential at this time...remains at risk for falls due to poor safety awareness/cognitive impairments. Continued use of self-releasing belt in w/c indicated...." A care plan titled, "Falls" dated 03/01/2011 indicated, "Falls At risk for fall/injury AEB [as evidence by] History of Falls...poor safety awareness...." Interventions included, but were not limited to, "...Call light within reach...Wheelchair...Lock breaks [sic] on bed, chair etc before transferring...self releasing seat belt...." Restraint/Enabler Circumstance, Assessment and Intervention form, dated 02/03/11, indicated a self-releasing seat belt alarm was considered. "Fall" was circled as the reason for request.			

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A Fall Circumstance, Assessment and Intervention form, dated 02/17/11 at 4:30 p.m., indicated Resident #50 was found on the floor of the bathroom. The form indicated, "...Placed in B.R. [bathroom]. The form lacked documentation of the specific circumstances of the incident. The form indicated the activity at the time of the fall was transferring self and toileting. An entry on the "Fall" care plan, dated 02/17/11, indicated to evaluate the function of the seatbelt.

A Fall Circumstance, Assessment and Intervention form, dated 02/27/11 at 7:45 a.m., indicated the resident fell in the bedroom without injury. "...Bedside mat..." was added to "Fall" care plan.

A Fall Circumstance, Assessment and Intervention form, dated 03/18/11 at 10:15 a.m., indicated Resident #50 was found on the floor and was transferring self. "Resident to remain in common areas..." was added to "Fall" care plan.

A Fall Circumstance, Assessment and Intervention form, dated 04/18/11 at 1:00 p.m., indicated Resident #50 was found on the floor of the resident's room. The activity at the time of the fall indicated Resident #50 was transferring self. , "...Remind staff to re-connect seat belt

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	155680	A. BUILDING 00 B. WING	08/19/2011

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	{the sign for after} meals...." was added to "Fall' care plan. A Fall Circumstance, Assessment and Intervention form, dated 04/27/11 at 4:30 p.m., indicated resident fell and to continue with all safety measures. The form indicated the resident was trying to stand. A Fall Circumstance, Assessment and Intervention form dated 05/28/11 at 1:50 p.m., indicated the resident took apart alarm and tried to ambulate and fell in the television lounge. A "Fall" care plan entry, dated 05/28/11, indicated, "...MD notified of [sign for increase] anxiety. A Fall Circumstance, Assessment and Intervention form, dated 05/11/11 at 11:00 a.m., indicated resident lifted the lift chair independently and attempted to transfer self. Other comments indicated to contact the family to provide a different chair. A Fall Circumstance, Assessment and Intervention form, dated 07/05/11 at 11:00 a.m., indicated Resident #50 fell in resident's room. The form indicated, "...Resident's chair alarms working , but @ x [time] of fall it was off...." Other comments indicated, "...Staff education to turn SB [seat belt] back on [sign for after] meals....'			

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	A Fall Circumstance, Assessment and Intervention form, dated 07/29/11 at 9:00 a.m., indicated, Resident #50 fell in resident's room and complained of right hip pain. The activity at the time of fall was transferring self. The form indicated, "Equipment inspection: Safety equipment in place and functioning at time of incident?...." A capital "N" was circled at the end of that line. "....Wheelchair brakes locked?...." A capital "N" was circled at the end of that line. The other comments indicated, "...staff educ [educated] Therapy screen...." A Rehabilitation Screen for Resident #50, dated 08/01/11, indicated, "...Report of fall in room...possibly attempting to transfer self...remains fall risk...poor safety awareness. Continues [sign for with] self-releasing (alarm) seat belt...No skilled intervention this date...." A Rehabilitation Screen for Resident #50, dated 08/10/11, indicated, " ...continues to require alarming seat belt...No skilled intervention this date...." During an interview on 08/18/11 at 1:10 p.m., the Director of Nursing (DoN) indicated staff was re-educated to fasten seat belt after meals. the DoN indicated staff had been re-educated multiple times.			

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	The DoN indicated Resident #50 should not have had access to remote on lift chair and fall reports should be more detailed. 4. On 8/15/11 at 9:45 A.M., during an initial tour with LPN #1, Resident #17 was identified as being in a wheelchair, incontinent, having a bed and chair alarms, and having had a fall the previous weekend with no injuries. On 8/15/11 at 11:50 A.M., Resident #17 was observed sitting in a wheelchair in the dining room. There was a chair alarm in place. On 8/16/11 at 3:05 P.M., Resident #17 was observed sitting in a wheelchair next to his bed in his room. There was a chair alarm in place. There was no motion sensor in the room. Resident #17's clinical record was reviewed on 8/16/11 at 1:35 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, generalized cerebral atrophy, hydrocephalus, bipolar disorder, hepatic cirrhosis, and deconditioning. A hospital charting report, dated 7/19/11, indicated "...He is demonstrating significant memory difficulties that are consistent with his report and would			

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	certainly not be inconsistent with a generalized pathology such as normal pressure hydrocephalus...the patient clearly requires 24 hour supervision, and does not appear cognitively able to independently manage his own affairs at the present time...balance: fair to sit, poor to stand...up with assist; high fall risk (balance, cognition)..." A physician's admission orders, dated 8/6/11, indicated "...Safety Devices: bed alarm...Mobility: Up with assist only until cleared by PT (physical therapy)..." A physical therapy note, dated 8/8/11, indicated "...Decline in functional mobility with several recent falls backwards and difficulty walking...Balance...Static Standing...Fair...Dynamic Standing...Fair-/Fair...Fall Risk...Max (maximum)...Safety Awareness...Fair-...He presents with weakness, slow gait with decreased heel strike and difficulties with tranfers [sic]. He requires assist for gait and all mobility at this time..." A "Nursing Admission Assessment & Data Collection" form, dated 8/6/11, indicated "...Transfer with assist of one...Assistive device:...Walker/W/C (wheelchair)...Safety...Alarm type:			

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	bed...High fall risk, recent falls...Safety Plan of Care...Toilet resident per toileting schedule...Implement restraint to assist with fall prevention: Type: bed alarm..." An "Occupational Therapy Initial Plan of Care," dated 8/8/11, indicated "...Toilet hygiene...Mod (moderate)...Static Standing...Fair-...Dynamic Standing...Poor+...Fall Risk...High...Safety Awareness...Imp [impaired]..." A fax to the physician, dated 8/8/11, indicated "Res (resident) found sitting on floor in BR [bathroom]. ROM [range of motion] WNL (within normal limits). Denies pain or discomfort." A "Fall Circumstance Assessment and Intervention" form, dated 8/8/11 indicated "...Time of fall 1600 [4:00 PM]...Location of fall: Bathroom...Witnessed: N (no) (circled)...Found on floor: (indicated by checkmark)...Activity at time of fall: Transferring self (indicated by checkmark)...Toileting (indicated by checkmark)...Personal inspection:...Toileting needs (indicated by checkmark)...Safety equipment in place and functioning at time of incident? Y (yes) (circled)...Prevention Update...Bed alarm ...Being seen in therapy for multiple			

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	falls. Adding chair alarm..." Documentation was lacking related to whether the resident was sitting in a wheelchair or in bed at the time of the fall. A "Safety Plan of Care," dated 8/6/11 and updated 8/9/11, indicated "...chair alarm..." A fax to the physician, dated 8/9/11, indicated "...Fell in bathroom - small abrasion to coccyx (L) (left) upper back & (L) leg. Denies pain, able to move all extremities..." A "Fall Circumstance Assessment and Intervention" form, dated 8/9/11, indicated "...Time of fall 2P...Location of fall: restroom...Witnessed: N (no) (circled)...Found on floor: (indicated by checkmark)...Activity at time of fall: Transferring self (indicated by checkmark)...Personal inspection:...Toileting needs (indicated by checkmark)...Safety equipment in place and functioning at time of incident? Y (yes) (circled) alarm sounded...brought self to bathroom - wearing socks, slid...Prevention Update...Therapy evaluation...Frequently used items within reach...Nonskid footwear..Teach w/c safety...chair alarm (has)...Add non-skid footwear..." Documentation was lacking			

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	related to whether the resident was sitting in a wheelchair or in bed at the time of the fall. A "Safety Plan of Care," dated 8/6/11 and updated 8/10/11, indicated "...non-skid footwear..." A fax to the physician, dated 8/14/11, indicated "...Slid off side of bed trying to stand to use urinal. No injury noted..." A "Fall Circumstance Assessment and Intervention" form, dated 8/14/11, indicated "...Time of fall 2315 (11:15 P.M.)...Location of fall: (room number)...Witnessed: N (no) (circled)...Found on floor: (indicated by checkmark) next to bed...Activity at time of fall: Turning in bed (indicated by checkmark)...Turning in bed to use urinal slipped off side of bed...Resident had bed higher than usual with foot of bed elevated also...Safety equipment in place and functioning at time of incident? Y (yes) (circled)...Resident had moved bed higher off ground. Was attempting to stand next to bed to use urinal and was unable to touch the floor due to bed higher...Prevention Update...Call bell...Low bed...Bed in low position...Motion detector...Add scoop mattress..."			

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	A "Safety Plan of Care," dated 8/6/11, indicated documentation was lacking to address keeping the bed in low position and the use of a scoop mattress. Interview on 8/17/11 at 8:25 A.M., with OT (occupational therapist) #3 indicated Resident #17 was a high fall risk and his standing balance was "fair." He required assistance for toileting and ambulation. Interview on 8/17/11 at 8:28 A.M., with PT (Physical Therapist) #4 indicated Resident #17 "needs cueing" and was a high fall risk. She indicated there were "safety concerns." She stated "he has short-term memory problems." Interview on 8/16/11 at 3:06 P.M., with the Director of Nursing indicated the bed alarm "apparently was not sounding" for the 8/8/11 fall. She indicated the resident did not have a motion detector at the bedside. She indicated there was no documentation of a toileting program for the resident. 5. On 8/15/11 at 9:45 A.M., during an initial tour with LPN #1, Resident #44 was identified as being ambulatory with a walker, having no alarms, being incontinent, and having had no falls. On 8/16/11 at 2:35 P.M., with LPN #2,			

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	Resident #44 was observed ambulating with a walker to and from the bathroom. After leaving the bathroom, the resident went back to her bed. She left the walker at the bedside and started to walk to the door to the room. LPN #2 reminded the resident to get her walker. The resident got her walker and left the room with no staff in attendance and ambulated to the nurses' station. Resident #44's clinical record was reviewed on 8/17/11 at 12:40 P.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, atrial fibrillation, migraines, vomiting, urinary tract infection, and depression. A Minimum Data Set (MDS) 30-Day Assessment, dated 7/26/11, indicated the resident was cognitively intact, required limited one-person physical assistance for transfer, ambulation, and toilet use, was not steady but able to stabilize without human assistance, and had had one fall without injury. An "Occupational Therapy Initial Plan of Care," dated 6/1/11, indicated "...Static Standing...fair+...Dynamic Standing...fair...Fall Risk...mod (moderate)...."			

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	A "Physical Therapy Initial Plan of Care," dated 6/1/11, indicated "...Static Standing...fair-...Dynamic Standing...poor+...Fall Risk...Elevated..." A resident care plan, dated 6/20/11, indicated "...Falls...remind resident and reinforce safety awareness...appropriate footwear..." A fax to the physician, dated 7/9/11, indicated "...Resident found on floor near bathroom door. Res didn't call for assistance nor did she use her walker. No noticeable injuries but resident stated she hit her head & c/o [complains of] lower back pain..." A "Fall Circumstance Assessment and Intervention" form, dated 7/9/11, indicated "...Time of fall 0330 (3:30 A.M.)...Location of fall: residents room...Witnessed: N (no) (circled)...Found on floor: (indicated by checkmark)...Walking to bathroom unassisted without walker (non-compliant c [with] walker use)...Activity at time of fall: Transferring self (indicated by checkmark)...Toileting (indicated by checkmark)...Ambulating (indicated by checkmark)...Resident had no shoes or grippy socks...Safety equipment in place and functioning at time of incident? Present/Available...Resident chose to take			

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	self to bathroom without use of walker or staff assistance...Prevention Update...Toilet q20 [every two hours] as desired c [with] assistance...nonskid footwear...Remind resident to use walker & non-skid socks..." A resident care plan, dated 6/20/11 and updated 7/11/1,1 indicated "...non-slip socks..." Documentation was lacking to address toileting the resident every two hours. A nurses' note, dated 7/20/11 at 9:30 A.M., indicated "Residents [sic] seems to be confused @ times...Today resident is transferring self c [with] out safety devices. Writer reminding resident to use walker. Resident also as [sic] an unsteady gait et [and] c/o not feeling well..." A fax to the physician, dated 7/23/11, indicated "...Res [resident] became dizzy this AM when getting out of bed. Knees became weak et fell to knees the to [L] elbow et shoulder. 0 (no) injuries noted at this time..." A "Fall Circumstance Assessment and Intervention" form, dated 7/23/11, indicated "...Time of fall 0650 (6:50 A.M.)...Location of fall: Res room...Witnessed: N (no) (circled)...Found on floor: (indicated by			

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	X)...Activity at time of fall: Transferring self (indicated by X)...Toileting (indicated by X)...Ambulating (indicated by X)...Improper fitting footwear (indicated by X)...Safety equipment in place and functioning at time of incident? Y (yes)...Prevention Update...nonskid footwear...Call bell...Therapy to eval (evaluate)..." A resident care plan, dated 6/20/11 and updated 723/11, indicated "...Therapy to screen..." Documentation was lacking related to any other additional interventions implemented to prevent falls. An "Occupational Therapy Progress Note," dated 7/31/11, indicated "...Noted confusion this week, requiring redirection with tasks...Safety cues for use of walker...Standing balance...Fair - dynamic balance/impulsive with forgetting to use walker..." Interview on 8/17/11 at 1:05 P.M., with CNA #5 indicated the resident had cognitive deficits and she required cueing to remember to use her walker. She indicated "because of her cognitive deficits she would be a fall risk." Interview on 8/17/11 at 1:25 P.M. with OT #6 indicated the resident was a "safety			

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	risk because of her confusion." She indicated the resident "has trouble sequencing" when performing tasks. She stated "I think she's a risk (falls)." Interview on 8/17/11 at 1:26 P.M., with PT #7 indicated Resident #44 required staff with her to provide verbal cues when ambulating. Interview on 8/17/11 at 1:27 P.M., with the Director of Nursing indicated the facility did not have any policies related to fall prevention. She indicated falls were "followed in CAR (clinically at risk) committee." She indicated the residents were "probably not on a toileting schedules." She indicated the facility did not have a toileting program because "we're waiting for a restorative aide to start in September." She stated "I understand your concerns." 3.1-45(a)(2)			

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F0371 SS=E	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure food items were labeled with the date opened and failed to ensure food was kept from potential contamination and not served to residents related to a menu and a ladle falling into a pot of ham and beans during meal service. This had the potential to affect 53 of 89 residents who received food from the kitchen. Findings include: During the initial kitchen tour on 08/15/11 at 9:30 a.m., with the Dietary Manager, an observation was made of food products stored with no open dates. In the walk- in freezer, 2 half gallon cartons of ice cream were opened with no open dates. In the walk-in refrigerator, 3 one gallon jugs of chocolate milk and 6 one gallon jugs of white milk were opened with no open dates. One carton of liquid eggs was opened with no open date. In the dry food storage area, four dry cereal bags were opened and sealed with no open dates. On 08/15/11 at 12:05 p.m., during lunch service, Cook #1 was serving ham and	F0371	Submission of this plan of correction does not constitute an admission by Homewood Health campus of any wrong-doing or failure to comply with the Federal or State Regulations. Homewood Health Campus submits this plan of correction as its letter of credible allegation and is requesting a desk review or a request for a revisit immediately after September 18, 2011. 1. All Dietary Staff that was present was immediately inservice regarding sanitation standards and the service of meals on August 16, 2011 for those residents found to have been affected by the deficient practice. The pest control company was immediately called for the flies that were sighted with no recommendations. The facility placed a blue bug light in the kitchen & both dining rooms which meets sanitation guidelines to attract flies. 2. DFS and or designee will monitor sanitation standards and meal service for other residents having the potential to be affected by the same deficient practice. Remaining dietary	09/02/2011

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	beans from a large pot with a ladle. A resident menu slip dropped into the pot of ham and beans that Cook #1 was serving from. Cook #1 removed the paper slip and continued to ladle ham and beans into resident serving bowls. On 08/15/11 at 12:06 p.m., two flies landed on clean plates that were being plated with resident food. On 08/15/11 at 12:08 p.m., the handle of the serving ladle became submerged in the same large pot of ham and beans that were being served. Cook #1 removed the ladle and continued to serve the ham and beans into resident serving bowls. Cook #1 had been handling the ladle handle with a bare hand. On 08/15/11 at 1:35 p.m., a fly was observed landing on the plate of food of Resident #16 in the Restorative Dining Room. On 08/16/11 at 5:16 p.m., a fly was observed landing on a soup bowl of Resident #27 in the Main Dining Room. On 08/15/11 at 12:15 p.m., the Dietary Manager indicated the ham and beans should not have been served after the menu and ladle came into contact with the		staff was inservice on 8.29.11 and 8.31.11 Our pest control company will continue to visit monthly and monitor for flies in our facility. 3. The following measures will be put into place to ensure that the deficient practice does not recur: DFS and or designee will monitor by observing random serving of meals, checking all open products for open dates, and checking for flies in the kitchen five times per week for three weeks, then three times per week times two weeks and then weekly for a total of six months. 4. All monitoring results will be reported each month to QA committee times six months for review and changes as needed to ensure the deficient practices will not recur. All corrective actions will be completed by 09.02.2011	

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	155680	A. BUILDING 00 B. WING	08/19/2011

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	ham and beans. The Dietary Manager indicated open dates should be on all food that is opened. On 08/18/11 at 2:00 p.m., during an interview, the Executive Director (ED) was made aware of the service of the ham and beans after contact with a resident menu and ladle handle. The three observations of flies were discussed. The ED indicated the back door of the kitchen led to a service hall that led to the outside. The ED described a blower mechanism at the top of this door to prevent flies from entering the kitchen. Kitchen policies regarding sanitation and food storage were requested at this time. On 08/18/11 at 2:20 p.m., a facility policy provided by the ED which was identified by the ED as current, titled, "Date Marking," indicated, "...2. When to date mark: A. If an opened food item is not used within 24 hours B. The food requires refrigeration B. [sic] A commercially-prepared item is opened D. When ready-to-eat-food item is stored regardless of temperature E. When potentially hazardous foods are stored...." On 08/18/11 at 2:20 p.m., a facility policy provided by the ED which was identified as current by the ED, titled, "Food Production Guidelines-Sanitation &			

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	Safety," indicated, "Policy: Safe and sanitary handling of food will be employed during food production...22. Plates, silverware, glasses, etc., are handled so hands do not touch the areas where the food or mouth will be placed...." 3.1-21(i)(2)			
F9999	3.1-13 ADMINISTRATION AND MANAGEMENT (g) The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual	F9999	Submission of this plan of correction does not constitute an admission by Homewood Health campus of any wrong-doing or failure to comply with the Federal or State Regulations. Homewood Health Campus submits this plan of correction as its letter of credible allegation and is requesting a desk review. 1. The administrator was immediately inservice on 08.19.2011 regarding immediately informing the division by telephone, followed by	09/02/2011

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	occurrences that directly threaten the welfare, safety, or health of the resident or residents. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure a significant injury was reported to the Indiana State Department of Health for 1 of 7 residents reviewed for falls in a sample of 14. (Resident #36) Findings include: 1. Resident #36's record was reviewed on 08/16/2011 at 1:35 P.M. Diagnoses included but were not limited to diabetes, congestive heart failure (CHF), and severe cardiomyopathy. An accident/incident report, dated 03/29/2011 at 12:15 A.M., indicated..."res [resident] found on floor at foot of lazy boy chair, lying on left side, states did not know how she got from chair to floor AOx3 [alert and oriented times three]. No visible injuries noted. Physician statement/orders: observe... Additional information: found out that [res] took sleep aide [sic] as prescribed prn [as needed] reminded [res] to lie down in bed. [Res] requesting to sit up in chair."		written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or heath or the resident or residents found to have been affected by the deficient practice. 2. The support nurse and or designee will review all unusual occurrences that directly threaten the welfare, safety, or heath or the resident or residents having the potential to be affected by the same deficient practice. 3. The following measures will be put into place to ensure that the deficient practice does not recur: All unusual occurences will be reviewed by the IDT each morning during morning meeting to ensure compiance in reporting timely to ISDH. 4. All monitoring results will be reported each month to QA committee times six months for review and changes as needed to ensure the deficient practices will not recur. All corrective actions will be completed by 09.02.2011.	

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An accident/incident report, dated 03/29/2011 at 4:40 A.M., indicated..."res sitting in chair asleep at 4:20 A.M., roommate call out [sic] at 4:40 A.M. when res fell getting up call lite [sic] on armrest." The report indicated "....observed on floor...no apparent injury.... neck pain...."

A history and physical from the hospital, dated 03/29/2011, indicated, "...resident who sustained 2 falls...she states she hit the right side of her head...the family believes she was given a sleeping pill before she went to sleep and got up on her own....radiology studies...CT [cat scan] of her neck shows C2 [cervical spine #2] vertebral body fracture and C5 fracture...."

A current facility policy titled, "Reportable Event Procedural Guidelines" no date, provided by the Administrator on 08/16/2011 at 2:45 P.M., indicated ... "Occurrences to be report [sic] include:...significant injuries (contact your divisional nurse to discuss injury on an individual basis),... unusual or life threatening injury...."

An interview with the Administrator and the DON on 08/16/2011 at 2:45 P.M., indicated the incidents were not reported to the Indiana State Department of Health.

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	The DON indicated the injury was reported to the divisional nurse and it was determined that the injury did not need to be reported. The DON indicated, "...the resident was alert and oriented and could tell us what happened...." 3.1-13(g)(1)			